

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

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2. STATE:

MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)
TITLE XIX

4. PROPOSED EFFECTIVE DATE

10-1-97

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 U.S.C. 1396r-4;
42 CFR 447.250-299

7. FEDERAL BUDGET IMPACT:

a. FFY 98 \$ 4,888.

b. FFY 99 \$ 5,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A(2.b)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

SAME

10. SUBJECT OF AMENDMENT:

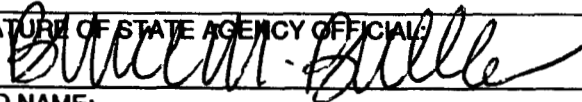
Non-State Owned Non-Acute Psychiatric Hospital

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

Not Required Under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Bruce M. Bullen

14. TITLE:

Commissioner

15. DATE SUBMITTED:

December 31, 1997

16. RETURN TO:

Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
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FOR REGIONAL OFFICIALS ONLY

17. DATE RECEIVED:

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18. DATE APPROVED:

Jan 4, 1998

19. EFFECTIVE DATE OR APPROVED NATIONAL:

December 1, 1997

20. APPROVED BY:

Ronald F. Preston

21. TITLE:

Acting Director, Division of Medical Assistance

22. REMARKS:

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**State Plan Under Title XIX of the Social Security Act
Massachusetts Medical Assistance Program**

**Methods Used to Determine Rates of Payment
for Non-State-Owned Psychiatric Hospital Services**

I. General Description of Payment Methodology

The following sections describe the methods and standards utilized by the Division of Medical Assistance ("Division") to establish rates of payment by contract, to be effective October 1, 1997 (Rate Year (RY) 1998), for services rendered by psychiatric hospitals to patients entitled to medical assistance under M.G.L. c. 118E, §1 *et seq.* These rates of payment do not apply to Recipients who are enrolled in the Division's Mental Health/Substance Abuse Program.

1. Hospital allowable costs, with the exception of the working capital component, are determined from a base year that has been fixed at FY 1984. These FY 1984 costs are restricted by the implementation of base-year cost screens that eliminate excessive costs. Expenses disallowed in the base year are never rolled into payment rates for subsequent years. The establishment of a fixed-base year, therefore, provides a strong incentive for cost efficiency. Rates of payment are adjusted to affect appropriate cost increases or decreases resulting from changes in volume, case-mix, inflation, and other factors. The working capital component is determined from the operating and capital requirements of the rate year.
2. Rates of payment have a direct relationship to the actual charges incurred by a patient based on the services utilized by that patient. Under this charge-based system hospitals are able to charge more for patients who require more services. Thus, this system is responsive to hospital financial needs in the face of changing patient utilization of services.
3. A payment-on-account factor (PAF), essentially a ratio of allowed hospital costs to allowed hospital charges, is also calculated for each hospital. A single payment-on-account factor will apply to a hospital's inpatient and outpatient services; Medicaid payment be equal to charges (or daily charge) times the payment-on-account factor.

II. Definitions

Adjusted Base Year Volume. The actual Base year volume adjusted to include the volume associated with recurring CBC's, new services and transfers on of cost and exclude volume associated with discontinued services and transfers off of cost.

Base Year. Base year shall mean the hospital's fiscal year 1984.

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CBC. Cost beyond control

Charge. The amount to be billed or charged by a hospital for each specific service within a revenue center.

Department of Mental Health (DMH). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 19, §1 *et seq.*

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 17, s. 1.

Discontinued Service. A health service, supply, or accommodation that conformed in scope to a cost center as defined in Chapter III of the Reporting Manual which:

- o is included in the adjusted base year cost and which will not be offered during the budget year, or
- o is being offered and terminated during the budget year.

Division of Health Care Finance and Policy (DHCFP). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 118G.

Division of Medical Assistance (Division) An agency of the Commonwealth of Massachusetts established under M.G.L. c. 118E.

FTEs. FTE is an acronym for full-time equivalent staff. To compute full-time equivalents (FTEs), divide the total annual paid hours (including vacation, sick leave and overtime) for all employees in each cost center by a forty (40) hour work week annualized to a norm of 2080 hours.

Governmental Unit. The Commonwealth of Massachusetts and any department, agency, board, commission, or political subdivision of the Commonwealth.

Gross Patient Service Revenue (GPSR). Gross patient service revenue is the total dollar amount of a hospital's charges for services rendered during the reporting period, generally within a fiscal year.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual, promulgated by DHCFP under 114.1 CMR 4.00.

Intermediate Year. The hospital fiscal year just before the current rate year.

Inpatient Day. HURM standard unit of measure to report care of patients admitted to a hospital including the day of admission, but not the day of discharge. If both occurs on the

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same day, the day is considered a day of admission and counts as one inpatient day.

Mental Health/Substance Abuse program (MH/SAP). A managed care program for the provision of mental health and substance abuse services to Recipients enrolled in the program.

Non-acute Hospital. A hospital that is defined and licensed under M.G.L. c. 111, s. 51, with less than a majority of medical surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, s. 29.

Payment on Account Factor (PAF). A percentage which applied to Charges to calculate the appropriate payment amount for inpatient services.

Psychiatric Hospital. Any psychiatric facility licensed under M.G.L. c. 19, s.29.

Rate Year. The rate year will be 10/1 to 9/30.

Recipient. A person determined by the Division to be eligible for medical assistance under the Medicaid Program.

Reasonable Financial Requirements (RFR). The sum of the hospital's rate year operating requirements, rate year capital requirements, and rate year working capital requirements.

State-Owned Non-acute Hospital. A hospital that is operated by the Massachusetts Department of Public Health (DPH) with less than a majority of medical surgical, pediatric, maternity and obstetric beds, or any psychiatric facility operated by the Department of Mental Health.

Transfer of Cost. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities that provide hospital care or services, and which change compensation arrangements from non-hospital based to hospital based (transfer on) or from hospital based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

III. Medicaid Reimbursement Methodology for Non-State-Owned Psychiatric Hospitals

For any particular rate year, a provider-specific Medicaid payment-on-account factor (PAF) will be calculated. This PAF is, in turn, applied to charges billed to the Division of Medical Assistance by the hospital. The PAF is the ratio of the hospital's rate year allowable costs, called "RFR" to the rate-year charges, called "GPSR". The Medicaid PAF is computed as follows:

- o Data Sources: Submission, review, and acceptance of hospital cost information;
- o Determination of Operating Requirement;

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- o Determination of Capital Requirement;
- o Determination of reasonable financial requirements (RFR) for the rate year;
- o Determination of approved gross patient revenue service (GPSR) for the rate year.

Each of these steps is explained in greater detail below.

III.A. Data Sources: Submission, Review and Acceptance of Hospital Cost Information.

Each non-state-owned Psychiatric Hospital must file with the DHCFP reports of its costs, revenues, statistics, charges, and other related information in accordance with time-frames and reporting mechanisms specified by the DHCFP. Exceptions to certain reporting requirements are allowed in specified circumstances.

Information reported by each hospital may be adjusted upon audit. If the specified data sources are unavailable or inadequate, payment rates will be determined using the best alternative data source and/or a statistical analysis will be performed to insure comparability of data.

III.B. Determination of Operating Requirement

The Operating Requirement is the sum of the allowed base year operating costs, adjustments to base year operating costs, inflation, volume, costs beyond control and new services.

1. Allowed Base Year Operating Costs: The base-year for allowed operating costs is FY 1984. This includes only costs incurred or to be incurred in the provision of hospital care and services, supplies, and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. ss. 1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual, the Massachusetts HURM (found at 114.1 CMR 4.00) and Generally Accepted Accounting Principles. A double stepdown cost allocation system is applied to these costs to determine full costs incurred by each hospital department. A double stepdown allows for full interdepartmental cost allocations between nonrevenue producing departments as well as revenue producing departments. The first stepdown distributes all direct and indirect costs of all departments to various cost centers according to a statistical basis of allocation. After the first stepdown is completed, the costs that have been allocated to the nonrevenue departments are then redistributed to the revenue-producing departments using the same statistical basis of allocation as in the first stepdown.

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2. Adjustments to Allowed Base-Year Operating Costs: Base-year operating costs as reported by the hospital are subject to the following limitations: base-year cost screens, adjustments to variables, and base year cost adjustments.
- a. Base-Year Cost Screens Base-year costs found to be excessive will be eliminated from allowable base-year costs. For psychiatric hospitals, a single base year cost screen is applied to adjusted total costs. The regression employed uses all psychiatric hospitals, with adjusted total cost as the dependent variable. Independent variables are: (1) Boston metropolitan location, (2) revenue/cost ratio, and (3) average length of stay.
 - b. Adjustments to Variables In the event that either audit results or information provided by a hospital change the variables used in the cost screens, the value of the affected cost caps for that hospital only will be recomputed. Any resulting changes to base-year allowable costs will be credited to the hospital at its next budget or charge modification review.
 - c. Base-Year Cost Adjustments Base-year costs may also be subject to adjustments stemming from audit results, from cost reductions resulting from discontinued services or the transfer off of costs, or to annualized base-year costs not in place during the full base year.
3. Inflation
- a. The allowed base year operating cost is adjusted using a composite index comprised of two cost categories: labor and non-labor. These categories are weighted according to the weights used by the Health Care Financing Administration for PPS-exempt hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index. The inflation proxy for the non-labor cost category is non-labor portion of the HCFA market basket for non-acute hospitals.
 - b. The composite inflation index as calculated in accordance with the preceding paragraph is increased by .02, in conformance with prior years' rate calculations.
4. Volume:
- Allowed base-year operating costs are further adjusted to reflect reasonable volume increases and decreases as follows:
- a. Each hospital is required to report its costs, revenue, and volume

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data, as described in Section III.A herein. For purposes of calculating the volume adjustment, the Allowed Unit Cost for each cost center equals the base year direct and indirect costs for that cost center divided by the year units. The volume associated with a Determination of Need (DoN) project, new service, or transfer on of cost is part of the volume used in the computation of the volume allowance, unless the costs associated with it are otherwise included as a CBC, new service or base year cost adjustment..

- b. For projected volume increases or decreases from the intermediate year to the rate year which are greater or equal to 10%, the hospital must submit a supporting statement of explanation accompanied by the appropriate statistical documentation. No volume increase is allowed without such explanation and documentation.
- c. For routine inpatient care services and routine ambulatory services, the allowed marginal cost for a unit increase or decrease in volume is 50%. The allowed cost for marginal cost for ancillary services for a unit increase or decrease in volume is 60%. There is no upside corridors for volume increases.
- d. An increase in costs due to an increase in routine inpatient services or routine ambulatory services volume from the base year to the rate year is calculated as the product of the projected increase in units multiplied by 50% of the allowed unit cost inflated by the base to rate year composite inflation index.

An increase in costs due to an increase in ancillary services volume from the base year to the rate year is calculated as the product of the projected increase in units multiplied by 60% of the allowed unit cost inflated by the base to rate year composite inflation index.

- e. For routine inpatient care services, routine ambulatory services and ancillary services, the allowed marginal cost for a unit decrease in volume is as follows:

<u>Unit Decrease</u>	<u>Allowed Marginal Cost</u>
Up to 5%	100%
Over 5% to 25%	50%
Over 25% to 50%	25%
Over 50% to 75%	12.5%
Over 75%	0%

There are no downside corridors for volume decreases.

- f. A decrease in cost due to a decrease in routine inpatient care service,

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routine ambulatory care services or ancillary services volume is calculated as the product of the projected decrease in units multiplied by one minus the applicable marginal cost percentage, as describes above, multiplied by the Allowed Unit Cost inflated by the base to rate year composite inflation index.

5. Costs Beyond Hospital Control (CBCs)

- A. Under specific circumstances, the allowed base year operating costs are adjusted to include cost increases due to a CBC. A CBC is an unusual and unforeseen increase in reasonable and allowable costs which is solely attributable to unique and exceptional circumstances that are beyond the control of the hospital. The following requirements must be met before certain costs are qualified as CBCs and included in the hospital's operating requirement.
- (1) A cost shall not be determined to be a CBC if in a prior fiscal year the DHCFP approved costs corresponding to the CBC and the events giving rise to the cost did not take place in the year the cost was approved.
 - (2) The hospital shall demonstrate that the category of cost of the requested CBC is not included in the adjusted base year operating cost or in the inflation and volume allowances.
 - (3) The timing and amount of the increase in costs must be reasonably certain.
 - (4) A CBC is allowable only if the amount requested is greater than one-tenth of 1% of the hospital's total patient care costs.
 - (5) Multiple unrelated CBC requests for any one cost beyond control category must not be grouped together. Each individual CBC request for a particular item must meet the materiality limit specified in (d) above.
 - (6) A CBC is allowable only if necessary for the appropriate provision of services to Recipients and if the costs cannot otherwise be met through efficient management and economic operation.
- B. The following are the qualifying incidents or circumstances for CBCs:
- (1) Costs generated by correcting deficiency contingencies or recommendations for failure to comply with changes in

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government requirements related to hospital licensure and participation in programs of hospital care and services under 42 U.S.C. §§ 1395 et seq. and 42 U.S.C. §§ 1396 et seq. An example of this category is a cost incurred or expected to be incurred within six (6) months to comply with a change in the manual issued after 1984 by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Costs of complying with standards contained in the manual before 1985 or costs which merely recommend improvement will not be considered as a CBC. Hospitals which have not previously been accredited by JCAHO will be allowed reasonable costs of complying with accreditation standards of the JCAHO contained in its manual. An example of cost which would not be considered to be a CBC is expanded emergency room coverage. Also, increased utilization review costs which are not due to any allowable CBC shall not be recognized. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the increased costs and verification that the increased costs are reasonable to meet the government requirement.

- (2) Costs generated by compliance with changes in government requirements which are set forth in federal or state regulations which mandate non-discretionary hospital expenditures. However, if the costs fall within a category encompassed by an inflation factor, it shall not be allowed as a cost beyond reasonable hospital control. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the costs, and verification that the increase in costs requested is reasonable to meet the government requirement.
- (3) Costs generated by disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources. Documentation shall include verification of loss or extraordinary cost and the insurance or outside source payment. If, however, the loss or extraordinary cost is caused by a facility being inadequately insured according to the standards of the hospital industry, or through negligence on the part of hospital management, such losses or costs shall not be approved.
- (4) Allowed operating costs associated with a major capital expenditure or substantial change in services which is subject to and has received a determination of need pursuant to

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M.G.L. c. 111, §§25B - 25G. These costs must be segregated from other allowed operating costs. The hospital must demonstrate that the increased cost requests are reasonable. The hospital will not be permitted to make a volume adjustment for departments affected by a determination of need if the hospital requests that the operating cost associated with the determination of need be included as a CBC. Any volume allowance due to DoN is netted out if costs associated with it are submitted as a CBC.

- (5) Wage parity adjustments resulting from mergers which are clearly demonstrated to be cost-effective. The term "cost-effective" used in this context shall mean that at the end of three years the merged hospitals are spending less than the individual hospitals have projected, and in no event are spending more than the combined projections of both hospitals. Documentation shall include a copy of the merger agreement and projections of costs without the merger as well as projection of the cost savings to be achieved through the merger. This adjustment will be considered a non-recurring cost beyond control and the costs associated with it will be subtracted from rate year costs for any year in which the rate year becomes the base year for future rates.
- (6) Intra-hospital wage and salary adjustments which are clearly demonstrated to be cost-effective. The term "cost-effective" as used in this context shall mean that at the end of three years the hospital is spending less than it would have without the wage and salary adjustments.
 - (a) Documentation shall provide a projection of the costs savings to be achieved as a result of adjustments to wages and salaries.
 - (b) This adjustment will be considered a non-recurring cost beyond control. Costs associated with this CBC will be subtracted from rate year costs for any year in which the rate year becomes the base year for future rate years.
- (7) Costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation. This CBC is not to exceed actual expenditures for such increases.
 - (a) Wage relief may be requested for technicians, nurses,

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